HCFA
Model M+C Organization
Evidence of Coverage
And
Disclosure Information

Effective January 1, 2000 through December 31, 2000

NOTE TO HEALTH PLANS: 42 CFR 422.111(a)(3) requires that: "An M+C organization must disclose...information...at the time of enrollment and annually thereafter." HCFA believes that in order to have relevance and in order to meet requirements of the law and regulations, an updated Evidence of Coverage (EOC) needs to be sent to all members by February 15, 2000. For members who were not effective or enrolled on January 1, the EOC must be mailed within two weeks of the effective date of coverage.

Prepared by the Health Care Financing Administration, Center for Health Plans and Providers, Health Plan Purchasing and Administration Group.

A Message from HCFA to Health Care Entities Participating in the Medicare + Choice Program

The Balanced Budget Act of 1997 (BBA) established a new program called the Medicare + Choice (M+C) program. This program significantly expands the health care options available to Medicare beneficiaries.

The Balanced Budget Act defined the terms "Medicare +Choice organization" and "Medicare + Choice plan" in ways which are not always compatible with the way the terms "organization" and "plan" have been used in the past. In previous HCFA documents, the term "managed care organization" was frequently used interchangeably with the term "managed care plan" or "health plan". Under the BBA, a Medicare + Choice organization is an entity that contracts with HCFA to offer a Medicare + Choice plan. The Medicare + Choice plan consists of the specific health benefits, terms of coverage, and pricing structure. The BBA also provides for several different types of Medicare + Choice plans to be available for beneficiaries. One type of Medicare + Choice plan is a coordinated care plan, which includes health maintenance organizations (HMOs), provider-sponsored organization (PSOs), and preferred provider organizations (PPOs).

Medicare + Choice organizations have requested help in drafting membership rules. This model Evidence of Coverage (EOC), also known as member contract or subscriber agreement, is in response to those requests. Please note that this is a model and Medicare + Choice organizations are free to develop their own language. However, approval will be expedited for those Medicare + Choice organizations choosing to use the model language.

It will simplify Regional Office review if you will highlight any changes you are making from your previously approved EOC.

Reference Page (inside front cover):

Please fill this out for your reference:

Your [name of M+C Plan] membership number _____
(located on your membership card)

Your Effective Date of enrollment _____

Questions? Problems? Need help?
Call or write your Customer Service Representative [1-800-xxx-xxxx - include TTY # for the "hearing impaired" - list hours of operation for both #s], [address]

(Bottom of Reference Page) **This combined Evidence of Coverage and Disclosure Information contains a schedule of the benefits and rights you have as a member of [name of M+C Plan]. This document will be mailed to you annually at the beginning of each contract year (Calendar Year) or shortly thereafter upon regulatory approval. This document is effective for the calendar year January 1, 2000, through December 31, 2000.**

Our contract with HCFA is renewed on an annual basis. At the end of each contract year, the contract can be ended by either the M+C Organization or Medicare. If the M+C Organization nonrenews the contract, you will receive a minimum ninety-(90)-day notification before the end of the contract. If HCFA ends the contract you will receive a minimum thirty-(30)-day notification. If the contract ends, we will explain what your options are at that time.

[name of M+C Organization] does not discriminate in the employment of staff or in the provision of health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. Federal law mandates that the Plan comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

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[Note: The contracting entity may mail the EOC with a separate welcome letter to beneficiaries in the same package. However, this letter must be approved by HCFA and does not waive the requirement for the Welcome section provided below.]

Welcome to the [name of M+C Plan]!

This document is an explanation of your rights, benefits and responsibilities as a Member of the [name of M+C Plan], a "Medicare+Choice" (M+C) Plan offered by [name of M+C Organization], a [list type of coordinated care plan, i.e., HMO, PSO, PPO] with a Medicare+Choice contract. It also explains our responsibilities to you. Your Member Contract for [name of M+C Plan] consists of this combined Evidence of Coverage and Disclosure Information, your individual election form and any current or future amendments.

This combined Evidence of Coverage and Disclosure Information contains important information. Please read it carefully. Keep it in a safe place, available for quick reference.

[name of M+C Plan] is not an insurance policy that merely pays Medicare deductibles and coinsurance charges (commonly called a "Medigap" or "Medicare supplement" policy). Instead, [name of M+C Organization] has entered into a contract with the Health Care Financing Administration (HCFA), the Federal Government agency that administers Medicare. This contract authorizes [name of M+C Organization] to arrange for comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in [name of M+C Plan]. [name of M+C Plan] covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare.

Our contract with HCFA renews annually (on January 1). Either HCFA or [name of Health Plan] may terminate the contract, or a portion of the contract (or Service Area), by providing advance notice to each other and to you. If the contract ends, we will explain what your options are at that time.

By enrolling in [name of M+C Plan], you have made a decision to receive all of your health care from Contracting Medical Providers and facilities. You are also required to follow all plan member rules, such as obtaining referrals and prior authorization when required.

Of course, if you need Emergency Services or Urgently Needed Services (generally, outside of the area served under [name of M+C Plan]), those services will be covered. **However, if you receive services from Non-Contracting Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services or out-of-area renal dialysis services, neither [name of M+C Organization] nor Medicare will pay for those services.**

How You Can Learn More About Your Benefits

We encourage you to attend a Member education meeting where you can learn more about [name of M+C Plan] . A [name of M+C Organization] representative will lead the meeting and answer questions you may have about [name of M+C Plan].

You'll also become familiar with the services and assistance available through the [name of M+C Organization] Customer Service Department. To find out the dates and times of the next Member education meeting, call the Customer Service department.

Call our Customer Service Department Whenever You Need Information

In addition to arranging comprehensive medical benefits, we strive to provide you with the information you need about [name of M+C Plan] when you need it.
We have specially trained, [name of M+C Organization] Customer Service Representatives you can call when you have questions about:

Covered Services
Making address or phone number changes
Primary Care Physician changes
Enrollment or Disenrollment
Appeal and grievance rights
Medical care when you are traveling
The care you are receiving
Any other questions or concerns regarding your M+C Plan

You can reach the Customer Service Department [insert phone numbers include TTY # for the "hearing impaired" - list hours of operation for both #s]

Updating Your Membership Records

Your [name of M+C Organization] membership record contains information from your individual election form including your address and telephone number, as well as your specific M+C Plan coverage, and the Primary Care Physician and the Contracting Medical Group or IPA you selected upon enrollment. These records are very important because they identify you as an eligible [name of M+C Plan] Member and determine where you can receive covered services.

Please report any changes in name, address or phone number to the Customer Service Representative immediately. You should also report any changes in health insurance coverage you have from your employer or your spouse's employer. You should also report any liability claims, eligibility under workers' compensation, and Medicaid eligibility.

You Can Tell Us How We're Doing

Our goal is to arrange the Covered Services you need to stay as healthy and active as you can be. You can play a key role by telling us how we are doing.

From time to time, we will be asking your thoughts on the [name of M+C Plan] through our Member satisfaction surveys. These surveys help us measure the performance of our Contracting Medical Groups, IPAs and Contracting Medical Providers, as well as the quality of our Member service.

Your responses and comments help identify our strengths as well as areas for needed improvement.

Of course, you can call or write to us at any time with helpful comments, questions and observations. Your personal input is always welcome, whether it is concerning something you like about our plan or something you feel is a problem area.

Section 1 - Health Care Terms

The following definitions apply to this Evidence of Coverage and Disclosure Information. [Note: The contracting entity may choose not to include model definitions not applicable to the entity's contractual obligations with HCFA or enrolled Medicare beneficiaries.]

Annual Election Period -- The month of November is the annual election period for the following year. Organizations offering M+C plans in January of the following year must open enrollment to Medicare beneficiaries in November. During the annual election period, an individual eligible to enroll in an M+C plan may change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan.

Appeal -- Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service. These procedures include reconsiderations by the M+C Organization, an independent review entity, hearings before Administrative Law Judges (of the Social Security Administration), review by the Board, and judicial review.

Basic Benefits -- All health care services that are covered under the Medicare Part A and Part B programs except hospice services and additional benefits. All Members of [name of M+C Plan] receive all Basic Benefits.

Benefit Period -- A benefit period is a way of measuring your use of services under Medicare Part A. This is used to determine Medicare coverage, and coverage under [name of M+C Plan]. A benefit period begins with the first day of a Medicare covered inpatient hospital stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor of a skilled nursing facility (SNF).

Calendar Year -- A twelve- (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Center for Health Dispute Resolution (CHDR) -- An independent HCFA contractor that reviews appeals by members of Medicare managed care plans, including [name of M+C Plan].

Coinsurance -- The portion of the bill or contracted charge for which you (the Member) are responsible.

Continuation Area -- An area outside the [name of M+C Plan] service area where we arrange for continuation of coverage for our members who move outside the defined Service Area. Members must reside in the continuation area on a permanent basis, in order to retain eligibility for continued enrollment in [name of M+C Plan].

Contracting Hospital -- A Hospital that has a contract with [name of M+C Organization] or

your Contracting Medical Group or IPA to provide services and/or supplies to you.

Contracting Medical Group -- Physicians organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has an agreement with the [name of M+C Organization] to provide medical services to Members.

Contracting Medical Provider --A health professional, a supplier of health items, or a health care facility having an agreement with the [name of M+C Organization] or a Contracting Medical Group or an IPA, to provide or coordinate medical services to Members.

Contracting Pharmacy -- A pharmacy that has an agreement with us to provide you with medication(s) prescribed by your Contracting Medical Provider in accordance with [name of M+C Plan].

Copayment - The fee you pay at the time of medical services in accordance with [name of M+C Plan]. This is a set amount per visit.

County - A local administrative subdivision of a State, as defined by the State.

Covered Services - Those benefits, services and supplies listed in Section 16 of this brochure which are:

- Services provided or furnished by Contracting Providers or Authorized by [[name of M+C Organization] or [its Contracting Providers]].
- Emergency Services and Urgently Needed Services, for which you do not need Prior Authorization and which may be provided by non-Contracting Providers. (Please refer to section ___ for more information about Emergency Services and Urgently Needed Services).
- Post-stabilization services furnished by Non-Contracting Providers or Facilities that are authorized by us or were not pre-approved because [name of M+C Organization] did not respond to a request for pre-authorization for such services within 1 hour of the request (or because we could not be contacted for pre-authorization).
- Renal dialysis services provided while you are temporarily outside the Service Area.
- Any services for which we provide prior authorization or pre-approval. Those benefits, services and supplies which we must furnish or pay for under [name of M+C Plan] for plan members.

Covered Services includes Basic Benefits and Supplemental Benefits.
Custodial Care -- Care furnished for the purpose of meeting non-Medically Necessary personal needs which could be provided by persons without professional skills or training, such as

assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by [name of M+C Plan] or Medicare unless provided in conjunction with Skilled Nursing Care and/or skilled rehabilitation services.

Disenroll or Disenrollment -- The process of ending your membership in [name of M+C Plan].

Drug Formulary -- A continually updated list of prescription medications, that represents the current covered drugs under [name of M+C Plan]. The Drug Formulary contains both brand name drugs and generic drugs, all of which have FDA (Food and Drug Administration) approval.

Durable Medical Equipment -- Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, Durable Medical Equipment must be Medically Necessary and prescribed by a Contracting Medical Provider for use in your home. DME includes items such as oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines.

Effective Date -- The date your [name of M+C Plan] Plan coverage begins. We provide written notification of your Effective Date.

Emergency Medical Condition -- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services -- Covered inpatient or outpatient services that are 1) furnished by a provider qualified to furnish Emergency Services; and 2) Needed to evaluate or stabilize an Emergency Medical Condition.

Evidence of Coverage and Disclosure Information -- This document, which explains Covered Services and defines our obligations and your rights and responsibilities as a Member the [name of M+C Plan].

Exclusion -- Items or services which are not covered under this Evidence of Coverage. You are responsible for paying for excluded items or services.

Experimental Procedures and Items -- Items and procedures determined by [name of M+C Organization] and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, [name of M+C Organization] will follow HCFA guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare. Experimental Procedures and Items are not covered under this Evidence of Coverage.

Fee-for-Service Medicare -- A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare.)

Grievance -- Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are: Waiting times in physician offices; Rudeness or unresponsiveness of Customer Service Staff.

HCFA -- The Health Care Financing Administration, the Federal Agency responsible for administering Medicare.

Home Health Agency -- A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when Medically Necessary, when you are confined to your home and when authorized by your Primary Care Physician.

Hospice -- An organization or agency, certified by Medicare, that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital -- A Medicare-certified institution licensed by the State, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

[**NOTE TO HEALTH PLANS:** You should use the following (or a similar) definition of Hospitalist, if your plan uses physicians other than your member's primary care provider or the admitting specialist to oversee care while a member is hospitalized. In addition to the definition, you should also include a complete explanation of this practice in your Provider Directory and in Section 5 - Working with Your Contracting Medical Providers - of this Model EOC.]

Hospitalist - When you are admitted for a medically necessary procedure or treatment at a contracting [name of M+C Organization] hospital, your health care may be coordinated by a physician who specializes in treating inpatients. This allows your primary care provider to continue to see other patients in his or her office while you are hospitalized.

Independent Physicians Association (IPA) -- A group of physicians who function as a Contracting Medical Provider/Group yet work out of their own independent medical offices.

Lock-In -- An arrangement under which all Covered Services, with the exception of Emergency Services, Urgently Needed Services, or Out-of-Area Renal Dialysis Services, must be provided or authorized by your Contracting Medical Provider or your Primary Care Physician. (There are very limited exceptions to this rule, including the right to self-refer for Flu Shots and Mammography Screening services. See Section 16: Schedule of Medical Benefits for specific limitations that apply to self-referral for these benefits.) If you receive services from a Non-Contracting Medical Provider without Prior Authorization, except for Emergency Services, Urgently Needed Services, or Out-of-area Renal Dialysis Services, neither [name of M+C Organization] nor Medicare will pay for that care.

Medicaid -- A joint federal/State medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medicaid. Medicaid, unlike Medicare, can cover long-term care, such as custodial nursing home care. Medicaid can cover all or part of your Medicare premiums and/or deductibles and coinsurance, if your income and resources are low enough. You should inquire about Medicaid and related programs - Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, Qualified Individual - at your local Department of Social Services.

Medical Director -- A licensed physician who is an employee of [name of M+C Organization], and is responsible for the overall quality of the medical care we provide.

Medically Necessary -- Medical Services or Hospital Services which are determined by [name of M+C Organization] to be:

(a) Rendered for the treatment or diagnosis of an injury or illness; and

(b) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

(c) Not furnished primarily for the convenience of the Member, the attending physician, or other Provider of service.

Whether there is "sufficient scientific evidence" shall be determined by [name of M+C Organization] based upon the following: peer reviewed medical literature; publications, reports, evaluations and regulations issued by state and federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by [name of M+C Organization].

Medicare -- The Federal Government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A -- Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility Care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part A Premium -- Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If you are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state, or local government employment to be insured, you do not have to pay a monthly premium. If you do not qualify for premium-free Part A benefits, you may buy the coverage from Social Security if you are at least 65 years old and meet certain other requirements.

Medicare Part B -- Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medicare Part B Premium -- A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services whether you are covered by an M+C Plan or by original Medicare.

Medicare+Choice (M+C) Organization -- A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by HCFA as meeting M+C contract requirements. M+C Organizations can offer one or more M+C Plans. [name of M+C Organization] is an M+C Organization.

[name of M+C Organization] Customer Service -- A department of [name of M+C Organization] dedicated to answering your questions concerning your membership, benefits, grievances and appeals. A [name of M+C Organization] Customer Service representative is available to assist you during regular business hours by calling 1-800-xxx-xxxx [include TTY # for the "hearing impaired" - list hours of operation for both #s] or by writing to [Street address].

Medicare+Choice (M+C) Plan -- A policy or benefit package offered by a Medicare+Choice Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the Plan. An M+CO may offer more than one benefit Plan in the same Service Area. [name of M+C Plan] is an M+C plan.

Medicare+Choice (M+C) Coordinated Care Plans -- These are M+C Plans that use a network of providers that are under contract or arrangement with a Medicare+Choice Organization to provide covered benefits. [name of M+C Plan] is a Coordinated Care Plan.

Member -- You, the Medicare beneficiary entitled to received Covered Services, who have voluntarily elected to enroll in [name of M+C Plan] and whose enrollment has been confirmed by HCFA.

Non-Contracting Medical Provider or Facility -- Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract with [name of M+C Organization] to deliver Covered Services to you.

Office Visit -- A visit for covered services to your Primary Care Physician, Specialist, other Contracting Medical Provider or Non-Contracting Medical Provider upon Referral.

Open Enrollment -- If an M+C Plan is open, beneficiaries in original Medicare or any other M+C Plan can enroll in the M+C Plan. M+C Plans must always be open during November. They must also always be open to individuals exercising their rights under the Initial Coverage Election Period and the Special Election Period. Between now and December 2001, M+C Plans can choose when to be open for new enrollments and when they will be closed to new enrollments.

Optional Supplemental Benefits -- Additional non-Medicare covered benefits beyond the benefits included in Basic Benefits, which may be elected at a member's option. There is an additional Plan Premium associated with Optional Supplemental Benefits. Members of [name of M+C Plan] must voluntarily elect Optional Supplemental Benefits in order to receive them.

Organization Determination -- See Section 9 Appeal and Grievance Procedures.

Peer Review Organization (PRO) - - An independent contractor paid by HCFA to review Medical Necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the PRO also reviews Hospital discharges for appropriateness and quality of care complaints.

[NOTE TO HEALTH PLANS: You should use the following (or a similar) definition of PHOs, if your plan uses formal subnetworks where each enrollee, by selecting a specific primary care provider, is also selecting an entire subnetwork to which his or her primary care provider can make referrals. In addition to the definition, you should also include a complete explanation of this restriction in your Provider Directory, in Section 5 - Working with Your Contracting Medical Providers - of this Model EOC, and in pre-enrollment materials].

Physician Hospital Organization (PHO) -- A contracting organization that binds physicians to a specific hospital. In most cases, all hospital services, except for emergency and urgently needed services, must be obtained from the hospital with which your primary care physician is affiliated.

Plan Premium -- The [monthly/quarterly] payment to the M+C Organization that entitles you to the Covered Services outlined in this Evidence of Coverage.

Point of Service B A benefit that may be offered as part of an M+C plan, or as a member option in exchange for a premium. Under this benefit, members can receive services outside the plan network if they are willing to pay higher cost-sharing amounts. [name of M+C Plan] [offers/includes] a Point of Service benefit. POS is defined as a benefit option under which [name of M+C Plan] allows Members the option of receiving specified services outside the M+C plan's provider network. **[NOTE TO HEALTH PLANS:** If you offer a POS, you should also provide definitions in this section of your EOC of: Allowed Amount, Balance Billing, Coinsurance and Maximum Charge; in order to provide your members with a complete description of their potential financial liability for use of a POS benefit].

Prescription [Drug] Benefit Manager -- Firms that contract with Medicare+Choice Organizations to manage pharmacy services.

Prescription Unit -- The maximum amount (quantity) of medication that may be dispensed per prescription for a single Copayment. For most oral medications, the Prescription Unit represents a thirty (30)-day supply of medication. The Prescription Unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the Prescription Unit is set at a smaller quantity for your protection and safety.

Primary Care Physician/Provider (PCP) -- The [name of M+C Plan] contracting physician/provider you choose to coordinate your health care. Sometimes PCPs are associated with a Contracting Medical Group or IPA. Your Primary Care Physician/Provider is responsible for providing or authorizing Covered Services while you are a Member of [name of M+C Plan]. Primary Care Physicians/Providers are generally physicians of Internal Medicine, Family Practice or General Practice. However, they may also be other provider types, based on your preference and health care needs.

Prior Authorization -- A system whereby a Provider must receive approval from a Contracting Medical Group, IPA or [name of M+C Plan] before you receive certain health care services.

Provider-- Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Referral -- A formal recommendation by your Primary Care Physician or his/her Contracting Medical Group or IPA that you receive care from a Specialist, Contracting Medical Provider or Non-Contracting Medical Provider.

Service Area -- A geographic area approved by HCFA within which a Medicare+Choice eligible individual may enroll in a particular Medicare+Choice Plan offered by an M+C Organization.

Skilled Nursing Care -- Services that can only be performed by, or under the supervision of licensed nursing personnel.

Skilled Nursing Facility -- A facility which provides inpatient Skilled Nursing Care, rehabilitation services or other related health services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Special Election Period -- Special periods of time in which an enrollee can discontinue enrollment in an M+C plan and change his/her enrollment to another M+C plan or return to original Medicare. In the event of the following circumstances, a Special Election Period is warranted: the M+C plan in which the member is enrolled is terminated; the enrollee moves out of the service area or continuation area of the M+C plan; the M+C Organization offering the plan violated a material provision of its contract with the enrollee; or, the enrollee meets such other material conditions as HCFA may provide.

Specialist -- Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare) that your Primary Care Physician/Contracting Medical Provider may Refer you to.

State -- The State of [Insert State name], responsible for licensing and regulating the managed care organization.

Time-Sensitive -- A situation where waiting for a standard decision could seriously jeopardize your life or health, or your ability to regain maximum function.

Urgently Needed Services -- Covered Services provided when you are temporarily absent from the [name of M+C Plan] Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Contracting Medical Group is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through your Contracting Medical Group.

Utilization Review Committee -- A committee used by [name of M+C Organization] or a Contracting Medical Group, hospital or IPA to promote the efficient use of resources and the quality of health care. Duties of the Utilization Review Committee include prospective, current and retrospective review of medical services.

Section 2 - Eligibility, Enrollment, and Effective Date

Who is Eligible to Enroll in [name of M+C Plan] ?

General Requirements

Generally, a Medicare beneficiary is eligible to enroll in [name of M+C Plan] if the following two conditions are satisfied :

X He or she is entitled to Medicare Part A (see definition in Section 1 above) and is enrolled in Medicare Part B (see definition in Section 1 above) as of the effective date of enrollment in [name of M+C Plan]; and

X He or she lives in the Service Area covered by the [name of M+C Plan] as described in Section 15.

There are some exceptions to the general rule, though, and some other eligibility rules:

X A Medicare beneficiary is not normally eligible to enroll in [name of M+C Plan] if he or she has end-stage renal disease (ESRD) - that is, permanent kidney failure which requires regular kidney dialysis or a transplant to maintain life. However, if an individual is already enrolled with [name of M+C Organization] when he or she develops ESRD, and is still enrolled with [name of M+C organization] at the time he or she becomes entitled to Part A & Part B of Medicare [note to those M+C Organizations with an approved Continuation Area: add the following: (even if he or she is living in the Continuation Area)], then he or she can be enrolled in an M+C plan offered by [name of M+C Organization] provided he or she continues to live in the Service Area [or Continuation Area]. If you were a [name of M+C Organization]] enrollee when you developed ESRD, you cannot be disenrolled from [name of Organization]] for that reason.

X A person who was a Member on or before December 31, 1998 and who was on that day entitled only to Part B of Medicare was deemed to be an enrollee of [name of Plan] and is eligible to continue enrollment in [name of M+C Plan] if that person continues to reside in the Service Area [or Continuation Area]. (If you are later disenrolled from [name of M+C Plan], however, you are not eligible to enroll in the [name of M+C Plan] unless you satisfy the eligibility requirements under the heading "General Requirements," above).

X [For M+C Organizations with approved continuation areas, add the following:

X [A person enrolled in the [name of M+C Organization] and who lives in the Continuation Area of the [name of M+C Organization] when he or she becomes entitled to Part A and Part B of Medicare may enrollee in [name of M+C Plan].

X [An enrollee of [name of M+C Plan] who moves permanently from the Service Area to the Continuation Area of the Plan may continue enrollment in the [M+C Plan]].

X A Medicare beneficiary must complete and sign an individual enrollment-election form to enroll in [name of M+C Plan]. If another person assists in the completion of the individual enrollment-election form, that person must also sign.

X A Medicare beneficiary who has enrolled in [name of M+C Plan] agrees to abide by the Plan rules.

Beneficiaries who meet the above eligibility requirements cannot be denied membership in [name of M+C Plan] on the basis of health status.

Enrollment

There are a number of times at which an eligible individual may enroll in [name of M+C Plan]. Eligible individuals can enroll in [name of M+C Plan] at the following times:

X Initial Election Period. You may elect to enroll in an M+C Plan when you first become entitled to both Part A and Part B of Medicare. The Initial Election Period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B and ends on the last day of the month before the date on which you become eligible for both Parts of Medicare.

X Annual Election Period. During the month of November, all M+C Plans are required to accept enrollment-elections, which will be effective the following January 1. During the November Annual Election Period, you can enroll in [name of M+C Plan] or change your enrollment-election from [name of M+C Plan] to original Medicare or to a different M+C Plan. Beneficiaries enrolled in original Medicare or another M+C Plan may also change enrollment-elections to any other M+C Plan, or enroll in [name of M+C Plan].

X Special Election Period. Special periods of time in which an enrollee can discontinue enrollment in an M+C plan and change his/her enrollment to another M+C plan or return to original Medicare. In the event of the following circumstances, a Special Election Period is warranted: the M+C plan in which the member is enrolled is terminated; the enrollee moves out of the service area or continuation area of the M+C plan; the M+C Organization offering the plan violated a material provision of its contract with the enrollee; or, the enrollee meets such other material conditions as HCFA may provide.

X [Open Enrollment Period. Note: For Organizations with an "open" enrollment period, the DF/EOC must describe the open election period as well. Certain restrictions apply to election of an M+C MSA. See section 1851(e)(5)].

A completed [name of M+C Plan] individual enrollment-election form must be submitted in

order to be processed. [*Insert information on where to enroll/obtain enrollment-election form*]. Your decision to enroll in a M+C Plan is not considered effective on the date that we receive a completed election form from you or your authorized representative.

If for any reason an enrollment-election application is rejected by HCFA, we contact the applicant for additional information or provide instructions to follow regarding resubmission of the enrollment application.

You may not be enrolled in more than one Medicare+Choice Plan at any given time. If you are already a member of an M+C Plan when you elect enrollment with a different M+C Plan, membership in the old Plan will automatically be terminated on the effective date of your enrollment-election in the new M+C Plan.

When [name of M+C Plan] Coverage Begins

The Effective Date of enrollment in [name of M+C Plan] will depend on when [name of M+C organization] receives your signedand completed enrollment form . [Name of M+C organization] will send you a letter that tells you when your coverage begins.

In general, completed enrollment forms must be received by [Name of M+C organization] no later than the 10th of the month to be effective the first of the next month. Completed enrollment forms received after the 10th of the month will be effective the second month after your form is received by [Name of M+C organization]. For example, if [Name of M+C organization] receives your completed enrollment form on June 10, your Effective Date would be July 1. If your form was received on June 11, your Effective Date would be August 1.

There are two exceptions to this general rule:

X Initial Election Period. In the case of an enrollment when you first become entitled to both Part A & Part B of Medicare, your enrollment will be effective as of the first day of the month that you have coverage under both Medicare Part A and Part B.

X Annual Election Periods. Enrollment-elections received during the Annual Election Period in November are usually effective on January 1. However, if [name of M+C Plan] is "open" or has an Open Enrollment Period during the month of November, then completed enrollment forms received between November 1 and November 10 can be effective December 1.

From the Effective Date forward, all Covered Services must be received from [name of M+C Plan] Contracting Medical Providers, except for Emergency Services, Urgently Needed Services, out-of-area dialysis services or Covered Services for which Prior Authorization has been obtained. **If a [name of M+C Plan] enrollee receives services from Non-Contracting Medical Providers without Prior Authorization, except for Emergency Services, Urgently Needed Services, or out-of-area dialysis services, neither the M+C Organization nor Medicare will pay for those services.** [**NOTE TO ORGANIZATION**: M+C Organizations with exceptions to

the above "lock-in" language should include appropriate language (e.g. POS, PPO, etc.)]

About your Medicare Supplement (Medigap) Policy

If you were enrolled in Original Medicare before you enrolled in [name of M+C plan], and you have a Medicare supplement (Medigap) policy, you may wish to cancel the policy. This is because premiums, copayments, or other amounts that M+C plans charge for Medicare covered services will not be reimbursed by Medicare supplement policies.

However, if you later disenroll from [name of M+C plan][the M+C plan], you may not be able to purchase another Medigap policy of your choice, because the Medigap insurer may be entitled to refuse to sell you a policy, or place limits on the policy, based on your health status.

In certain cases, you will be entitled to purchase specific Medigap policies without regard to your health status. In particular:

X If you are involuntarily disenrolled from [name of M+C Plan] for a reason that does not involve any fault on your part (e.g., you move out of the [name of M+C Plan] Service Area or [name of M+C Plan] no longer provides Medicare services), you will be entitled to purchase any Medigap Plan "A," "B," "C" or "F" sold in your State.

X If this is the first time you have enrolled in a Medicare managed care plan, and you voluntarily disenroll within twelve months, you will be entitled to purchase the same Medigap policy you had before, if it is still available from the same insurer. If it is not available, you will be entitled to purchase any Medigap Plan "A," "B," "C" or "F" sold in your State.

Note that if you enrolled in [name of M+C plan] when you first became eligible for Medicare at age 65, and disenroll within twelve months, you will be entitled to purchase any Medigap policy sold in your State.

In any of these situations, you must apply for the Medigap policy no later than 63 days after your coverage under [name of M+C Plan] terminates, although you may apply before your coverage ends in order for the Medigap policy to take effect as soon as you return to Original Medicare. You will be required to provide the Medigap insurer with evidence of the date your coverage ends. Please call the [name of M+C organization] Customer Service for additional information regarding your guaranteed right to purchase a Medigap policy.

Section 3 - [name of M+C Plan] Member Rights and Responsibilities

As a [name of M+C Plan] Member, you have the ***right*** to:

Timely, Quality Care

- Choice of a qualified Contracting Primary Care Physician and Contracting Hospital. (Note: Your plan can let you know if a specific physician is not accepting new patients at this time. Your physician will discuss with you the hospital that best fits your needs in the event of needing hospital services.)

- Candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

- Timely access to your Primary Care Physician and Referrals to Specialists when Medically Necessary.

- Receive Emergency Services when you, as a prudent layperson, acting reasonably would have believed that an Emergency Medical Condition existed and payment will not be withheld in cases where you seek Emergency Services.

- Actively participate in decisions regarding your own health and treatment options.

X Receive urgently needed services when traveling outside the Plan's service area or in the Plan's service area when unusual or extenuating circumstances prevent you from obtaining care from your Primary Care Physician.

Treatment with Dignity and Respect

- Be treated with dignity and respect and to have your right to privacy recognized.

- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both the Plan and contracting providers.

- Confidential treatment of all communications and records pertaining to your care. You have the right to access your medical records. The Plan must provide timely access to your records and any information that pertains to them. Written permission from you or your authorized representative shall be obtained before medical records can be made available to any person not directly concerned with your care or responsible for making payments for the cost of such care.

- Extend your rights to any person who may have legal responsibility to make decisions on your behalf regarding your medical care.

- Refuse treatment or leave a medical facility, even against the advice of physicians (providing you accept the responsibility and consequences of the decision).

- Complete an Advance Directive, living will or other directive to your Contracting Medical providers.

[name of M+C Plan] Information

- Information about [name of M+C Plan] and Covered Services.

- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.

- Receive information about an illness, the course of treatment and prospects for recovery in terms you can understand.

- Information regarding how medical treatment decisions are made by the Contracting Medical Group or [name of M+C Plan], including payment structure

- Information about your medications -- what they are, how to take them and possible side effects

- Receive as much information about any proposed treatment or procedure as you may need in order to give an informed consent or to refuse a course of treatment. Except in cases of Emergency Services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

- Reasonable continuity of care and to know in advance the time and location of an appointment, as well as the physician providing care.

- Be advised if a physician proposes to engage in experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.

- Examine and receive an explanation of any bills for non-Covered Services, regardless of payment source.

Timely Problem Resolution

- Make complaints and appeals without discrimination and expect problems to be fairly examined and appropriately addressed.
- Responsiveness to reasonable requests made for covered services.

As a Member of [name of M+C Plan], you have the ***responsibility*** to:

- Provide your physicians or other care Providers the information needed in order to care for you.
- Do your part to improve your own health condition by following treatment plans, instructions and care that you have agreed on with your physician(s).
- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.
- Accept the financial responsibility for any Copayment or Coinsurance associated with covered services received while under the care of a physician or while a patient at a facility.
- Review information regarding Covered Services, policies and procedures as stated in your Member Handbook or combined Evidence of Coverage Information.
- Ask questions of your Primary Care Physician or [name of M+C Plan] . If you have a suggestion, concern, or a payment issue, we recommend you call the [name of M+C Organization] Customer Service.

Section 4 - How Your [name of M+C Plan] Coverage Works

Your [name of M+C Plan] Membership Card

Your [name of M+C Plan] Membership Card is your passport to receiving all your [name of M+C Plan's] Covered Services. In nearly all instances, you will need to present your membership card to your health care Provider to verify your coverage and/or obtain Covered Services.

Carry your [name of M+C Plan] membership card (and your Medicare card) with you at all times.

Although you never need to give up your Medicare card, you must now use your [name of M+C Plan] card to receive Covered Services.

It is important that you use only your [name of M+C Plan] membership card B **NOT** your Medicare card -- for these reasons:

To prevent you from receiving medical services from Non-Contracting Medical Providers in error;

In the case of an Emergency Medical Condition, to alert hospital staff of the need to notify your Primary Care Physician or [name of M+C Plan] as soon as possible so that [name of M+C Plan] is involved in the management of your care; and

To prevent errors in billing. The [name of M+C Plan] pays the bills on behalf of Medicare. Medicare will not pay the bills while you are a Member of [name of M+C Plan].

[Insert Membership Card Diagram here]

If you lose your membership card or move, please contact your [name of M+C Organization] Customer Service Representative.

How the Lock-In Feature Works for You and the [name of M+C Plan]

As a [name of M+C Plan] Member, all your medical benefits (except for Emergency Services and Urgently Needed Services) are provided and arranged by your Primary Care Physician, a personal physician you choose from our list of Contracting Medical Providers. You are "Locked-In" to this Provider who will provide and coordinate all your routine health care services. [Note: Plans may cross-refer to specific information about any exceptions to the "Lock-In" Feature.]

The "Lock-In" feature is key to you and the [name of M+C Plan]. The [name of M+C Organization] is able to offer you this Plan because of our contract with the Health Care Financing Administration (HCFA), the government agency that oversees Medicare. Under this

contract, the Federal Government agrees to pay us a fixed monthly dollar amount for each Member we serve. We use the monthly amount received from the Federal Government to contract with medical groups, Hospitals and other health care Providers to arrange care for you.

If you receive services from Non-Contracting Medical Providers without Prior Authorization, except for Emergency Services, Urgently Needed Services, or Out-of-Area Renal Dialysis Services, neither [name of M+C Organization] nor Medicare will pay for those services.

Section 5 - Working With Your Contracting Medical Providers

Your Primary Care Physician/Provider

Your relationship with your Primary Care Physician/Provider is an important one. That's why we strongly recommend you choose a Primary Care Physician/Provider close to your home. Having your Primary Care Physician/Provider nearby makes receiving medical care and developing a trusting and open relationship that much easier.

Once you have chosen your Primary Care Physician/Provider, we recommend that you have all your medical records transferred to his/her office. This will give your Primary Care Physician/Provider access to your medical history, and make him or her aware of any existing health conditions you may have.

Always ask to see your Primary Care Physician/Provider when you make an appointment. Your Primary Care Physician/Provider is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. When you select a Primary Care Physician/Provider it is important to remember that this may limit you to the panel of Specialists who are affiliated with your Primary Care Physician/Provider. [Note: Medicare +Choice Organizations should modify the PCP/specialist phrase to reflect the plans' own contractual circumstances. If your plan uses formal subnetworks where each enrollee, by selecting a specific primary care provider, is also selecting an entire subnetwork to which his or her primary care provider can make referrals, you should include a complete explanation of this restriction here.]

You Can Change Primary Care Physician/Provider

Changing Primary Care Physician/Provider*
If you wish, you may request to change Primary Care Physician/Provider at any time. Your request will be effective *[Insert effective date & if new Membership card will be issued.]* Call [name of M+C Organization] Customer Service for assistance. [If a telephone # is listed, then a number for the "hearing impaired" must also be listed, along with hours of operation for both #s.]

Changing Primary Care Physician/Provider within Your Contracting Medical Group or IPA*
If you wish, you may request to change Primary Care Physician/Provider within your Contracting Medical Group or IPA at any time. Your request will be effective *[Insert effective date & if new Membership card will be issued.]* Call [name of M+C Organization] Customer Service for assistance. [If a telephone # is listed, then a number for the "hearing impaired" must also be listed, along with hours of operation for both #s.]

Choosing a New Primary Care Physician/Provider Who Is with a Different Contracting Medical Group or IPA *

If you want to change to a Primary Care Physician/Provider who is affiliated with a different Contracting Medical Group or IPA, you must contact [name of M+C Organization] Customer Service. If your request is received on or before the *[Insert date of month]* of the month, the transfer will become effective on the first day of the following month. If your request is received after *[Insert date of month],* the transfer will become effective the first day of the month following the month of your request. You will receive a new [name of M+C Plan] Membership Card that shows this change.

[insert example]

**[*Note: The M+CO should select the option(s), from those provided above, that most closely describe the provider arrangements and rules for changing PCPs that are in effect for their members]*.

To help promote a smooth transition of your health care when you change your Contracting Medical Group or IPA, please let us know if you are currently seeing a Specialist, receiving Home Health Agency services, or using Durable Medical Equipment. [name of M+C Organization] Customer Service can assist with the transfer of your care or equipment.

We will make every effort to notify you within 15 days of the date we are notified of the termination of any plan health care provider that affects you. Since our contract with our providers requires them to give us notice at least 60 days in advance of their voluntary termination, you should have at least 30 days to select a new health care provider before the termination is effective. We will assist you in selecting a new primary care provider or making sure you continue to have access to all provider services in the Plan's benefit package.

How to Schedule an Appointment with your Primary Care Physician/Provider

It's easy B simply call your Primary Care Physician's/Provider's office and request an appointment. There are no special rules to follow. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner.

The telephone number for your [*PCP, Contracting Medical Group or IPA, M+C Plan*] is listed on your membership card.

If at all possible, please call your Primary Care Physician/Provider 24 hours in advance if you are unable to make it to a scheduled appointment.

How to Receive Covered Services from a Specialist

Even though your Primary Care Physician/Provider is trained to handle the majority of common health needs, there may be a time when he or she feels you need more specialized treatment. In that case, you may receive a Referral to an appropriate Specialist. In some cases this may be a specialist within our network that your Primary Care Physician/Provider has previously chosen to refer his or her patients to. Not all specialists are available to all patients. In some cases, the request for a Referral will need to have Prior Authorization from a Utilization Review Committee.

Once your Primary Care Physician's/Provider's Referral request is approved, an appointment will be set with the Specialist. If for any reason you receive a bill from a Specialist, simply forward it to us for payment. See page 27 for where to send your claim.

[Name of M+C Plan] has approved procedures to identify, assess, and establish treatment plans (including direct access visits to specialists) for members with complex or serious medical conditions. In addition, we will maintain procedures to ensure that members are informed of health care needs that require follow-up and receive training in self-care and other measures to promote their own health.

Hospitalization, Home Health Care, Skilled Nursing Care & Hospice

If your Primary Care Physician/Provider determines that you require Hospitalization, Home Health Care, or Skilled Nursing Care he or she will arrange these Covered Services for you.

Please refer to your Summary of Benefits [Comparison of Benefits] for further details.

As a [name of M+C Plan] Member, you are entitled to impartial information regarding all available Medicare-certified Hospice Providers. Please call the [name of M+C Organization] Customer Service at [1-800_____include TTY # for the "hearing impaired" - list hours of operation for both #s] to obtain this information.

[Note: If your plan uses physicians other than your member's primary care provider or the admitting specialist to oversee care while a member is hospitalized, you should provide a complete explanation of this practice here.]

Receiving Care After Hours

If you need to talk to or see your Primary Care Physician/Provider after his or her office has closed for the day, call the *[24-hour number]* located on your [name of M+C Plan] membership card. The physician/provider on call will return your call and advise you on how to proceed. [Note: M+C Organization should insert applicable plan-specific information if different from above approach. Also note that the M+C Organization needs to make arrangements for the "hearing impaired" to have access to a 24-hour number. This might take the form of listing a "relay" number here that the member can use to contact their PCP after hours.]

Section 6 - Emergency and Urgently Needed Services

Emergency Services

Prior Authorization for treatment of Emergency Medical Conditions is not required.

In the event of an Emergency Medical Condition, go to the closest emergency room, or call 911 for assistance. [name of M+C Plan] will cover Emergency Services whether you are in or out of the Service Area.* You should have someone telephone *[[name of M+C Organization] or Primary Care Physician or Contracting Medical Group]* at the number listed on your membership card as soon as reasonably possible.

[***NOTE TO HEALTH PLAN:**

If you offer a "world-wide" emergency benefit, then you should say so here. You can say: "[Name of M+C Plan] offers world-wide emergency coverage."

If you offer the same emergency benefit as original fee-for-service Medicare, then you should say so here. You can say: [Name of M+C Plan] offers the same emergency coverage as does the original fee-for-service Medicare program, including:

X Coverage anywhere in the United States and its territories.

X Coverage for emergencies that occur when the member is in Canada while traveling without unreasonable delay and by the most direct route between Alaska and another state.

X Coverage for emergency inpatient hospital services furnished in a Canadian or Mexican hospital closer to, or more accessible from, the beneficiary's United States residence than the nearest participating United States hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury.

X Coverage for physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization.

X Coverage for services furnished on board a ship in a U.S. port, or within 6 hours of when the ship arrived at, or departed from a U.S. port. Services not furnished in a U.S. port, or furnished more than 6 hours before arrival, or after departure from, a U.S. port are considered to have been furnished outside U.S. territorial waters, even if the ship is of U.S. registry.

If you offer more than original Medicare, but less than "world-wide" emergency coverage, then you will need to include the five bullets above (original fee-for-service coverage) and explain the additional emergency coverage you offer here.]

Emergency Services are Covered inpatient or outpatient Services that are furnished by a

Provider qualified to furnish Emergency Services; and needed to evaluate or stabilize an Emergency Medical Condition.

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

X Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
X Serious impairment to bodily functions; or
X Serious dysfunction of any bodily organ or part.

It is important to notify *[[name of M+C Organization], Primary Care Physician, Contracting Medical Group or IPA]* of an Emergency Medical Condition so that [he/she or we or they] can be involved in the management of your health care and transfer can be arranged when your medical condition is stable (depending on the distance involved). Please contact your *[Primary Care Physician, Contracting Medical Group or IPA, us]* at the number located on your [name of M+C Plan] membership card within forty-eight (48) hours or as soon as reasonably possible.

If you have an Emergency Medical Condition while out of the Service Area, we prefer that you return to the Service Area to receive follow-up care through your Primary Care Physician. However, follow-up care will be covered out of the Service Area as long as the care required continues to meet the definition for either Emergency Services or Urgently Needed Services (see the definition below).

If you have an Emergency Medical Condition within the Service Area, you must receive any follow-up care through your Primary Care Physician.

Post-Stabilization Care

[Name of M+C Plan] also provides coverage for non-Emergency Services needed to ensure that you remain stabilized if:

We provide preauthorization for such services; or

We do not respond within 1 hour to a request for preauthorization from a Non-Contracting Medical Provider or Facility (or [name of M+C Org.] could not be contacted for preauthorization).

Coverage for Post-Stabilization Care is effective until:

X you are discharged;
X a Contracting Medical Provider arrives and assumes responsibility for your care; or

X the Non-Contracting Medical Provider and the M+C Plan agree to other arrangements.

Urgently Needed Services

The M+C Plan will also cover Urgently Needed Services.

Urgently Needed Services are Covered Services provided when you are temporarily* absent from the M+C Plan's Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Contracting Medical Group is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required

X **as a result of an unforeseen illness, injury, or condition; and**
X **it is not reasonable given the circumstances to obtain the services through your Contracting Medical Group.**

*A temporary absence is an absence from the Service Area lasting not more than 12 months.

You may seek care from a Hospital emergency room, other medical facility or doctor. If you must visit a provider, facility or Hospital for Urgently Needed Services when outside the Service Area, you should contact *[[name of M+C Organization], Primary Care Physician, Contracting Medical Group*] within forty-eight (48) hours or as soon as reasonably possible, so that *[we, he/she, it]* can be involved in the management of your care. While we prefer that you return to the Service Area to receive follow-up care through your Primary Care Physician, medically necessary follow-up care will be covered out of the Service Area when the care required continues to meet the above definition of Urgently Needed Services, or if your return to the service area would jeopardize your life or health.

Remember, if you receive services from Non-Contracting Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither [name of M+C Plan] nor Medicare will pay for those services.

Refunds for Emergency or Urgently Needed Services Paid by Member

Providers should submit bills to [name of M+C Organization] for payment. However, if you paid for any Emergency Services, Urgently Needed Services, or out-of-area dialysis services obtained from Non-Contracting Medical Providers, you should submit your bills to [name of M+C Organization] for payment. Bills should be submitted to the following address:

HMO
P.O. Box xxxx
Somewhere, State xxxxx-xxxx

If you have questions about any bills, contact Customer Service at 1-800 XXX-XXXX [include TTY # for the "hearing impaired" - list hours of operation for both #s]

Right to Appeal

We provide you with a written notice every time a service or payment is denied. If [name of M+C Organization] or your Contracting Medical Group has denied payment for services you think should have been covered, or if we refuse to arrange for services that you believe are covered by Medicare, you have the right to appeal. See Section 9.

Section 7 - Premiums & Payments

As a Member of [name of M+C Plan], you have the following financial obligations:

X **All Copayments/Coinsurance** shall be paid at the time of service. Specific Copayment/Coinsurance amounts are listed in Section 16.

X **Medicare Part B Premium** --As a [name of M+C Plan] Member you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is automatically deducted from your check. Otherwise your Premium is paid directly to Medicare by you or someone on your behalf (such as your State Medicaid agency).

X **Medicare Part A Premium** -- Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Part A). If you are not entitled to Medicare Part A, and you have purchased Part A through Social Security, you must continue to pay your Medicare Part A Premium. If you would like to purchase Part A from Social Security, please call your local Social Security Office or call 1-800 772-1213 toll free. For the hearing impaired the toll-free number to reach Social Security on is 1-800 325-0778.

X **[name of M+C Plan] Part A "Equivalent" Benefit Premium --** If you are not entitled to Medicare Part A and have not purchased Part A through Social Security, and you have purchased an "Equivalent Part A Benefit" from us in the past, you are entitled to continue to pay this amount and continue your coverage, provided that your membership with us started prior to January 1, 1999. The 2000 monthly premium for the [name of M+C Plan] Part A Equivalent Benefit Premium is $___.

NOTE: If you are enrolled in Part B and not entitled to Part A and you Disenroll from [name of M+C Plan], you will not be eligible to re-enroll in [name of M+C Plan] or any other Medicare+Choice Plan until you first purchase Part A coverage from Social Security. (See Section 1 - Definition of Part A Premium).

For details on Disenrollment for non-payment of premiums, please see Section 8.

Your Premium Payment Options

As a [name of M+C Plan] Member, you have [two] options for paying your monthly Plan Premium, or any other premiums that may be associated with Optional Supplemental Benefits or your [name of M+C Plan] Part A Equivalent benefit Plan Premium. These are the [provide names of programs]. If you are interested in the [name of option], simply [Insert State specific directions]

If you have any questions regarding your Plan Premium payment choices, please call [Insert State phone number include TTY # for the "hearing impaired" - list hours of operation for both #s] [Add any additional State specific information, such as mailing of new coupon books, timing of payments, e.g., date due, consequences of not paying on time, etc.]

Changes in Plan Premiums

Increases in Plan Premiums and/or decreases in the level of coverage are only permitted at the beginning of each contract year (which is based on the Calendar Year) and must be approved by HCFA. There will be no benefit changes during the Contract Year unless they are to your advantage. You will receive written notice by October 15 of the year before changes that are not to your advantage become effective.

Section 8 - Disenrollment From [name of M+C Plan]

Voluntary Disenrollment

You may choose to end your membership in [name of M+C Plan] for any reason. If you wish to disenroll, write a letter or complete a Disenrollment form and send it to the [name of M+C Organization] Customer Service department. We will send you a copy of your written request to disenroll.

The date of your disenrollment will depend on when [name of M+C Organization] receives your written request to enroll.

In general, written requests to disenroll must be received by [Name of M+C organization] no later than the 10th of the month to be effective the first of the next month. Written requests to disenroll that are received after the 10th of the month will be effective the second month after your request is received by [Name of M+C organization]. For example, if [Name of M+C organization] receives your disenrollment request on June 10, your Effective Date would be July 1. If your request was received on June 11, your Effective Date would be August 1.

There is an exception to this general rule. Disenrollment requests received between November 1 and November 10 are usually effective December 1. However, since the month of November is also the Annual Election Period, you can ask for a January 1 effective date.

[Name of M+C organization] will send you a letter that tells you when your disenrollment begins.

You may also disenroll through any Social Security Administration or Railroad Retirement Board office.

Even though you have requested disenrollment, you must continue to receive all covered services from [name of M+C Plan] Contracting Medical Providers until the date your disenrollment is effective.

You will be covered by Original Medicare after you Disenroll from [name of M+C Plan] unless you have joined another Medicare+Choice Plan.

Moves or Extended Absences From the [name of M+C Plan] Service Area

If you are permanently moving out of the [name of M+C Plan] Service Area, or plan an extended absence, it is important to notify us of the move or extended absence before you leave the Service Area. You may be eligible to continue to receive benefits if you are in the Plan's continuation area, as described in Section 15.

Failure to notify [name of M+C Organization] of a permanent move or an extended absence may

result in your involuntary disenrollment from [name of M+C Plan]. We are required to disenroll you if you permanently move outside the service area. (An absence from the service area [and continuation area, if applicable] of more than 12 months is considered a permanent move. See Section 15). If you remain enrolled after a move or extended absence (and have not been involuntarily disenrolled as described above), you should be aware that services will not be covered unless they are received from a [name of M+C Plan] provider in the [name of M+C Plan] Service area (except for Emergency Services, Urgently Needed Services, out-of-area dialysis and Prior Authorized Referrals).

[name of M+C Organization] currently offers M+C Plans in the following [states/counties]: XX, XX, XX, XX, XX, XX, and XX. If you are moving outside of your [name of M+C Plan] Service Area, you may be eligible to enroll in a different M+C Plan offered by [name of M+C Organization] in your new location. Plan Premiums, Copayments/Coinsurance and Covered Services may vary from one area to another, please contact M+C Organization Customer Service at 1-800-XXX-XXXX [include TTY # for the "hearing impaired" - list hours of operation for both #s] for information and assistance in completing any necessary paperwork. You may also call 1-800-MEDICARE for information on other plans available in your new area, or visit HCFA's website at www.medicare.gov.

Involuntary Disenrollment

The [name of M+C Organization] may Disenroll you from [name of M+C Plan] only under the conditions listed below. You will not be Disenrolled due to your health status.

1. If you move permanently out of the Service Area and do not voluntarily Disenroll or choose Continuation of coverage[A];

2. If your entitlement to Medicare Part A or enrollment in Part B benefits ends;

3. If you supply fraudulent information or make misrepresentations on your individual election form which materially affects your eligibility to enroll in [name of M+C Plan] [A,B];

4. If you are disruptive, unruly, abusive or uncooperative to the extent that your membership in [name of M+C Plan] seriously impairs our ability to arrange Covered Services for you or other individuals enrolled in the plan. Involuntary Disenrollment on this basis is subject to prior approval by HCFA[A];

5. You allow another person to use your [name of M+C Plan] membership card to obtain Covered Service[A,B];

6. You fail to pay the Plan basic [or optional supplemental, if applicable] Premiums. Disenrollment in this case is subject to the 90-day grace period for late payment of premiums[A]; or

7. The contract between the [name of M+C Organization] and HCFA under which [name of M+C Plan] is offered is terminated[C], or the [name of M+C Plan] service area or continuation area is reduced.[A]

[A] Disenrollment on these grounds can only occur after you have been provided notice with an explanation of the reasons for the disenrollment and information on [name of M+C Organization] applicable grievance rights. HCFA must also be notified, if disenrollment is due to reasons 3-5.

[B] Requires a referral to the Inspector General and may result in criminal prosecution;

[C] The contract with HCFA is renewed on an annual basis. At the end of each contract year, the contract can be ended by either the M+C Organization or HCFA. If the M+C Organization ended the contract, you would receive a minimum ninety-(90)-day notification before the end of the contract. If HCFA ended the contract you would receive a minimum thirty-(30)-day notification. We would explain what your options are at that time. For example, there may be other M+C Plans in the area for you to join, if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental health insurance. Whether you enroll in another Medicare+Choice Plan or not, there would be no gap in Medicare coverage. Until returning to Original Medicare coverage, you would still be a Member of [name of M+C Plan].

Until you are notified in writing of your Disenrollment, you are still considered a [name of M+C Plan] Member and must continue to receive Covered Services from Contracting Medical Providers. Neither the [name of M+C Plan] nor Medicare will pay for services received from Non-Contracting Medical Providers, except for Urgently Needed Services, Emergency Services [anywhere in the world], out-of-area dialysis services and Referrals that have received Prior Authorization.

Review of Termination and Reinstatement

No Member shall be Disenrolled because of the Member's health status or requirements for health care services. Any Member who believes he/she was Disenrolled by the [name of M+C Organization] because of the Member's health status or requirements for health care services should bring the matter to the attention of the local HCFA Regional Office.

[NOTE TO HEALTH PLAN: In the event there are specific State requirements related to involuntary disenrollment and/or if M+CO members have additional rights through a State mandated grievance process when involuntary disenrollment is initiated, please list those additional rights here.]

Section 9 - Appeal and Grievance Procedures

As a [name of M+C Plan] Member, you are encouraged to let us know if you have concerns or experience any problems with [name of M+C Plan]. We have representatives available to help you with your questions and concerns.

The procedures described in this section may be used if you have an appeal or grievance that you want to submit to [name of M+C Organization] for review and resolution. These procedures include:

X General Information on Medicare Appeals Procedures
X Medicare Standard Organization Determinations and Appeals Procedures
X Medicare Expedited/72-Hour Determinations and Appeals Procedure
X The M+C Organization Grievance Procedure
X Peer Review Organization (PRO) Immediate Review Of Hospital Discharges
X PRO Quality of Care Complaint Procedure
[If applicable, add other procedures you offer, or procedures required by your state, e.g., arbitration procedures, state-regulated complaint hotline]

General Information on Medicare Appeals Procedures

As a Member of [name of M+C Plan], you have the right to appeal any decision about our payment for, or failure to arrange or continue to arrange for, what you believe are Covered Services (including non-Medicare covered Benefits) under [name of M+C Plan]. Coverage decisions that are commonly appealed include decisions with respect to:

X Payment for Emergency Services, Post-Stabilization Care, or Urgently Needed Services;

X Payment for any other health services furnished by a Non-Contracting Medical Provider or Facility that you believe should have been arranged for, furnished, or reimbursed by [name of M+C Organization];

X Services you have not received, but which you feel [name of M+C Organization] is responsible to pay for or arrange; or,

X Discontinuation of services that you believe are Medically Necessary Covered Services.

You should use the [name of M+C Organization] Grievance Procedure (discussed below) for complaints that do <u>not</u> involve coverage decisions such as those set forth. If you have a question about what type of complaint process to use, please call Customer Service.

As discussed below, [name of M+C Organization] has a standard determination and appeals procedure and an expedited determination and appeals procedure.

Who May File an Appeal

1. You may file an appeal.

2. Someone else may file the appeal for you on your behalf. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:

    a. Give us your name, your Medicare number and a statement which appoints an individual as your representative. (Note: you may also appoint a physician or a Provider.) For example: A I __[*your name*]__ appoint __[*name of representative*]__ to act as my representative in requesting an appeal from the M+C Organization and/or the Health Care Financing Administration regarding the denial or discontinuation of medical services.

    b. You must sign and date the statement.

    c. Your representative must also sign and date this statement unless he/she is an attorney.

    d. You must include this signed statement with your appeal.

3. A Non-Contracting Physician or other Provider who has furnished you a service may file a standard appeal of a denied claim if he/she completes a waiver of payment statement which says he/she will not bill you regardless of the outcome of the appeal.

Support for Your Appeal

[name of M+C Organization] is responsible for gathering all necessary medical information relevant to your request for reconsideration (appeal). However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Physician. If your medical records from a Specialist are not included in your medical record from your Primary Care Physician, you may need to make a separate request to the Specialist who provided medical services to you.

You have the opportunity to provide additional information in person or in writing. In the case of an expedited decision or appeal, you or your authorized representative may submit evidence, in person, via telephone, or in writing transmitted by FAX at the address and telephone number referenced above under the expedited/72-hour review procedure. (Please call the M+C Organization if you need additional information or assistance on the procedures for submitting evidence to support your appeal.)

Assistance With Appeals

Regardless of whether you file a standard appeal or ask for an expedited review, you can have a friend, lawyer or someone else help you. There are lawyers who do not charge unless you win your appeal. Groups such as lawyer referral services can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify. You may want to contact the [Agency Name]__[*phone number*], or the [Agency Name] at __[*phone number*] [include TTY # for the "hearing impaired"(if one is available) - list hours of operation for both #s.]

Medicare Standard Organization Determination and Appeals Procedures

If you specifically request a particular service from your PCP or from a specialist or other provider you have been authorized to see, or if that PCP or specialist or other provider specifically requests authorization for a service for you from [name of M+C Organization] [or your Contracting Medical Group or IPA], it is a request for an organization determination on the service. If you request in writing to [name of M+C Organization] [or your Contracting Medical Group or IPA] at [address] that [we/they] make payment for a service you have already received, it is a request for a [name of M+C Organization] determination on the payment.

In the case of a Standard Determination, [name of M+C Organization] *[or your Contracting Medical Group or IPA]* must make a determination (decision) on your request for payment or provision of services within the following time frames:

X Request for Service. If you request services, or require Prior Authorization of a Referral for services, [name of M+C Organization] *[or your Contracting Medical Group or IPA]* must make a decision as expeditiously as your health requires, but no later than fourteen (14) calendar days after receiving your request for service. An extension of up to fourteen (14) calendar days is permitted, if you request the extension or if we have a need for additional information and the extension of time benefits you; for example, if we *[or your Contracting Medical Group or IPA]* need additional medical records from Non-Contracting Medical Providers that could change a denial decision.

X Requests for Payment. If you request payment for services already received, the M+C Organization *[or your Contracting Medical Group or IPA]* will usually make a decision on whether or not to pay the claim no later than thirty (30) calendar days from receiving your request, but in no case will this period exceed sixty (60) days.

[name of M+C Organization] *[or your Contracting Medical Group or IPA]* must notify you in writing of any adverse decision (partial or complete) within the time frames listed above. The notice must state the reasons for the denial and also must inform you of your right to a file an appeal. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60) days of a request for payment, you may assume the decision is a denial, and you may file an appeal.

If you decide to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

1. You must submit a written request for a reconsideration to [name of M+C Organization] *[department name; i.e., Appeals and Grievance Unit]* at *[address]*. You may also request a reconsideration through the Social Security office (or, if you are a railroad retirement beneficiary, through a Railroad Retirement Benefits Office). You must submit your written request within sixty (60) calendar days of the date of the notice of the initial decision.

   Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day time frame.

2. [name of M+C Organization] will conduct a reconsideration and notify you in writing of the decision, using the following time frames:

   X Request for Service. If the appeal is for a denied service, we must notify you of the reconsideration decision as expeditiously as your health requires, but no later than thirty (30) days from receipt of your request. We may extend this time frame by up to fourteen (14) days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we *[or your Contracting Medical Group or IPA]* need additional medical records from Non-Contracting Medical Providers that could change a denial decision. Again, we must make a decision as expeditiously as your health requires, but no later than the end of any extension period.

   X Request for Payment. If the appeal is for a denied claim, the M+C Organization must notify you of the reconsideration determination no later than sixty (60) days after receiving your request for a reconsideration determination.

   Our reconsideration decision will be made by a person(s) not involved in the initial decision. All reconsiderations of adverse organization determinations based on "lack of medical necessity" must be made by a physician with appropriate expertise in the field of medicine appropriate for the services at issue. You or your authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing to the M+C Organization.

3. If we decide fully in your favor on a request for a service, we must provide or authorize the requested service within thirty (30) days of the date we received your request for reconsideration. If we decide fully in your favor on a request for payment, we must make the requested payment within sixty (60) days of the date we received your request for reconsideration.

4. If we decide to uphold the original adverse decision, either in whole or in part, we will automatically forward the entire file to the Center for Health Dispute Resolution (CHDR) for a new and impartial review. CHDR is HCFA's independent contractor for appeal reviews involving Medicare+Choice managed care plans, like [the M+C Organization]. We must send CHDR the file within 30 days of a request for services and within 60 days of a request for payment. CHDR will either uphold the M+C Organization's decision or issue a new decision. If we forward the case to CHDR, we will notify you of our decision as discussed above.

5. For cases submitted for review, CHDR will make a reconsideration decision and notify you in writing of their decision and the reasons for the decision. If CHDR upholds our decision, their notice will inform you of your right to a hearing before an Administrative Law Judge of the Social Security Administration (see below for further levels of appeal). If CHDR (or a higher appeal level) decides in your favor, we must pay for, provide or authorize the service as expeditiously as your health condition requires, but no later than 60 days from the date we receive notice reversing our decision.

If CHDR does not rule fully in your favor, there are further levels of appeal:

6. If there is at least $100 in controversy, you may request a hearing before an administrative law judge (ALJ) by submitting a written request with the M+C Organization, CHDR or the Social Security Administration within sixty (60) days of the date of CHDR's notice that the reconsideration decision was not in your favor. This sixty- (60) day notice may be extended for good cause. All hearing requests will be forwarded to CHDR. CHDR will then forward your request and your reconsideration file to the hearing office. [name of M+C Organization] will also be made a party to the appeal at the ALJ level.

7. Either you or [name of M+C Organization] may request a review of an ALJ decision by the Board, which may either review the decision or decline review.

8. If the amount involved is $1000 or more, either you or [name of M+C Organization] may request that a decision made by the DAB, or the ALJ if the DAB has declined review, be reviewed by a Federal district court.

9. Any initial or reconsidered decision made by [name of M+C Organization], CHDR, the ALJ, or the Board can be reopened by any party (a) within twelve months, (b) within four (4) years for just cause, or (c) at any time for clerical correction of an error or in cases fraud.

10. The reconsidered determination is final and binding upon the M+C Organization. If there is a binding arbitration clause in your contract or on your individual election form, it does not apply to disputes subject to HCFA's appeals process.

Medicare Expedited/72 -Hour Determination and Appeal Procedure

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize your life or health, or your ability to regain maximum function. If [name of M+C Organization] [or your Contracting Medical Group or IPA] decides, based on medical criteria, that your situation is Time-Sensitive or if any physician makes the request for you or calls or writes in support of your request for an expedited review, we will issue a decision as expeditiously as your health requires, but no later than seventy-two (72) hours after receiving the request. We may extend this time frame by up to fourteen (14) days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we *[or your Contracting Medical Group or IPA]* need additional medical records from Non-Contracting Medical Providers that could change a denial decision. Again, we must make a decision as expeditiously as your health requires, but no later than the end of any extension period.

Types of Decisions Subject to Expedited/72-Hour Review

1. Expedited Determinations. If you believe you need a service, or continue to need a service, and you believe it is a Time-Sensitive situation, you or any physician (including a physician with no connection to [name of M+C Organization]) may request that the decision be expedited. If [name of M+C Organization] decides that it is a Time-Sensitive situation, or if any physician states that it is one, we will make a decision on your request for a service on an expedited/72-hour basis (subject to an extension as discussed above).

2. Expedited Appeals. If you want to request a reconsideration (appeal) of a decision by [name of M+C Plan] to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service and you believe it is a Time-Sensitive situation, you may request that the reconsideration (appeal) be expedited. If a physician wishes to file an expedited appeal for you, you must give him or her authorization to act on your behalf. If we decide that it is a Time-Sensitive situation, or if any physician states that it is one, we will make a decision on your appeal on an expedited/72-hour basis. We may extend this time frame by up to fourteen (14) days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we *[or your Contracting Medical Group or IPA]* need additional medical records from Non-Contracting Medical Providers that could change a denial decision. Again, we must make a decision as expeditiously as your health requires, but no later than the end of any extension period. Examples of service decisions which you may appeal on an expedited basis, when you believe it is a Time-Sensitive situation, include the following:

X If you received a denial of a service you requested;

X If you think services are being discontinued too soon. For example:

X If you think you are being discharged from a Skilled Nursing Facility too soon;

X If you think your Home Health care is being discontinued too soon;

X If you think you are being discharged from a Hospital too soon and you have missed the deadline for a Peer Review Organization (PRO) review.

The procedures for requesting and receiving an expedited determination or an expedited appeal (an expedited decision) are described in the following sections.

How to Request an Expedited/72-Hour Review
To request an expedited/72-hour review, you or your authorized representative may call, write, fax or visit [name of M+C Organization]. Be sure to ask for an expedited/72-hour review when you make your request.

Call: 1-800-XXX-XXXX
[Include Automated Attendant Option if applicable]

TDD/TDY 1-800-XXX-XXXX
[Business Hours]

Write: *[Expedited 72-Hour Review Unit]*
P.O. Box XXXX
City, State, Zip

Fax: 1-800-XXX-XXXX
Attention: *[Expedited 72-Hour Review Unit]*
[Business Hours]

Walk-in: *M+C Organization Customer Service Center*
[Address]
[City, State, ZIP]
[Business Hours]

How Your Expedited/72-Hour Determination/Review Request Will be Processed

1. Upon receiving your request for an expedited decision the [name of M+C Organization] [or your Contracting Medical Group, or IPA] will determine if your request meets the definition of Time-Sensitive.

X If your request does not meet the definition, it will be handled within the standard review process. You will be informed by telephone or in person whether your request will be processed through the expedited seventy-two (72) hour review or the standard review process. You will also be sent a written confirmation within two (2) working days of the phone call or personal contact. If you disagree with [name of M+C Organization's] decision to process your request within the standard time frame, you may file a grievance with [name of M+C Organization]. The written confirmation letter will include instructions on how to file a grievance. If your request is Time-Sensitive, you will be notified of our decision as expeditiously as your health requires but no later than seventy-two (72) hours after we receive the request.

X An extension up to fourteen (14) calendar days is permitted for a 72-hour request for determination/appeal, if you ask for the extension, or we need more information and the extension of time benefits you; for example, if you need time to provide us with additional information or if we need to have additional diagnostic testing completed.

2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited/72-hour review, and the physician indicates that applying the standard review time frame could seriously jeopardize your life or health or your ability to regain maximum function.

   X If a Non-Contracting Medical Provider supports your request, [name of M+C Organization] [or your Contracting Medical Group or IPA] will have 72 hours from the time it receives all the necessary medical information from that Non-Contracting Provider it needs to make a decision.

3. The M+C Organization will make a decision on your request for determination/appeal and notify you of it within 72-hours of receipt of your request. If we decide to uphold the original adverse decision, either in whole or in part, the entire file will be forwarded by the M+C Organization to CHDR for review as expeditiously as your health requires, but no later than 24 hours after our decision. CHDR will send you a letter with their decision within seventy-two (72) hours of receipt of your case from [name of M+C Organization].

There are four possible dispositions to a request for expedited determination/appeal. They are:

X Your request to expedite our determination/appeal decision is approved, we make a decision in 72 hours and notify you that we will provide or continue the service.

X Your request to expedite our determination/appeal decision is approved, we make a decision in 72 hours and notify you that we will not provide or continue the service.

X Your request to expedite our determination/appeal decision is not approved, and we tell you that your request will be handled under the standard determination/appeal process.

X Your request to expedite our determination/appeal decision cannot be made in 72 hours, and we let you know that we will need up to an additional 14 days to process your request.

When you request an expedited determination/appeal, if you do not hear from us within 72 hours of your request, you can assume that your request has been denied. Our failure to notify you in a timely manner - within 72 hours - constitutes a denial which you may appeal.

If you have questions regarding these rights, please call M+C Organization Customer Service at 1-800-XXX-XXXX [include TTY # for the "hearing impaired" - list hours of operation for both #s.]

[Name of M+C Organization] Grievance Procedures

As a M+C Plan Member, you have the right to file a complaint -- also called a grievance -- about problems you observe or experience, including:

X Complaints about the quality of services that you receive;

X Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns;

X Involuntary Disenrollment situations (see Section 8);

X If you disagree with our decision to process your request for a service or to continue a service under the standard 14 day time frame rather than the expedited/72-hour time frame;

X If you disagree with our decision to process your appeal request under the standard 30-day time frame rather than the expedited/72 hour time frame.

We will attempt to resolve any complaint that you might have. We encourage the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. However, if your complaint cannot be resolved in this manner, a more formal Member grievance procedure is available.

To use the formal grievance procedure, submit your grievance in writing to the Customer Service department. We will write you to let you know how we have addressed your concern within [number of days] of receiving your written grievance. In some instances we will need additional time to address your concern. If additional time is needed, the we will keep you informed regarding the status of your grievance. *[Include additional state-specific grievance procedures here.]* In either event, whether you use the formal (written) or informal (telephone) grievance procedure, we are required to track all appeals and grievances in order to report cumulative data to HCFA and to our members, upon request, beginning in early calendar year 2000.

However, complaints about a decision regarding payment for, or provision of, Covered Services that you believe are covered by Medicare and should be provided or paid for by the M+C Organization must be appealed through the M+C Organization's Medicare Appeals Procedure (see above).

Peer Review Organization (PRO) Immediate Review of Hospital Discharges

You have the right to receive all the Hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs. When you are being discharged from the hospital, you will receive a written notice of explanation called a "Notice of Non-Coverage" or "Notice of Discharge and Medicare Appeal Rights." This document outlines your rights, and you do not have to disagree with the noncoverage determination in order to receive it. Either [name of M+C Organization] or the hospital is required to issue this notice. You have the right to request a review by a Peer Review Organization (PRO) of any written Notice of Non-Coverage/Notice of Discharge and Medicare Appeal Rights that you receive from [name of M+C Organization] or from the Hospital on our behalf stating that we will no longer pay for your Hospital care. Such a request must be made by noon of the first workday after you receive the Notice. You cannot be made to pay for the Hospital care or services you received before the PRO made its decision and notified you.

PROs are groups of doctors who are paid by the Federal Government to review Medical Necessity, appropriateness, and quality of Hospital treatment furnished to Medicare patients, including those enrolled in a managed care plan (like [name of M+C Plan]). The phone number and address of the PRO for your area is:

[Insert PRO address and phone number include TTY # for the "hearing impaired" (if available) - list hours of operation for both #s*]*

Note: You should review your Notice of Non-Coverage/Notice of Discharge and Medicare

Appeal Rights to verify the address and phone number of the PRO responsible for the hospital in which you are a patient.

If you ask for immediate review by the PRO by noon on the workday following a Notice of Non-Coverage/Notice of Discharge and Medicare Appeal Rights, you will be entitled to this process instead of the standard appeals process that is described above in this section. You will also be protected from liability for hospital services you received before the PRO makes its decision. Instead of PRO review you may appeal the Notice of Non-Coverage/Notice of Dischange and Medicare Appeal Rights within 60 days as discussed above by requesting that [name of M+C Organization] reconsider the decision. The advantage of the PRO review is that you will get the results within three working days if you request the review on time. Also, you are not financially liable for hospital charges incurred during the PRO review process. This same protection does not apply in the case of the [name of M+C Organization] reconsideration process.
Note: You may file an oral or written request for an expedited/72-hour [name of M+C Organization] appeal only if you have missed the deadline for requesting the PRO review. If you do not seek PRO review, however, and seek an expedited reconsideration of the Organization Determination, you will be financially responsible for the hospital costs incurred from the date the Notice of Non-coverage/Notice of Discharge and Medicare Appeal Rights is issued if the Original Determination to discharge you is upheld through the appeal process. Specifically state that you have missed the immediate PRO review deadline, you want an expedited (or 72-hour) appeal and that you believe your health could be seriously harmed by waiting for a standard appeal.

Peer Review Organization Quality of Care Complaint Process
If you are concerned about the quality of care you have received, you may also file a complaint with the Peer Review Organization (PRO) in your local area. (The name, address and telephone number of your local PRO are referenced in the section above.)

Section 10 - Advance Directives: Making Your Health Care Wishes Known

We are required by law to inform you of your right to make health care decisions and to execute advance directives. **An advance directive is a formal document, written by you in advance of an incapacitating illness or injury.** As long as you can speak for yourself, Contracting Medical Providers will honor your wishes. But, if you become so sick that you cannot speak for yourself, then this directive will guide your health care Providers in treating you and will save your family, friends and physicians from having to guess what you would have wanted.

There may be several types of advance directives you can choose from, depending on state law. Most states recognize:

X DPAHC (Durable Power of Attorney for Health Care),
X Living Wills, and
X Natural Death Act Declarations.

This *[Insert any State specific language*] form allows you to appoint an agent (family, friend or other person) whom you trust to make treatment decisions for you should there come a time you are unable to make them yourself. You can purchase the form from a stationery store or ask for a form from your Contracting Medical Provider, a [name of M+C Organization] Customer Service Representative or social worker.

It is necessary that you provide copies of your completed directive to:

1. your Primary Care Physician,
2. your agent, and
3. your family.

Be sure to keep a copy with you and take a copy to the Hospital when you are hospitalized for medical care.

You are not required to initiate an advance directive, and you will not be denied care if you do not have an advance directive.

If you believe your Provider has not complied with your Advanced Directive, you may file a complaint with [List appropriate state specific agency here].

Section 11 - Coordinating other Benefits You May Have

Who Pays First?

If you are aged 65 or older and have coverage under an employer group plan of an employer of twenty (20) or more employees, either based on your own current employment or the current employment of a spouse, you must use the benefits under that plan. Similarly, if you have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) either through your own current employment or that of a family member, you must use the benefits under that plan. In such cases, you will only receive benefits not covered by your employer group plan through our contract with Medicare. A special rule applies if you have or develop End-State Renal Disease (ESRD).

If any no-fault or any liability insurance (or payment from a liable third party) is available to you, then benefits under that plan (or from that liable third party) must be applied to the costs of health care covered by this plan. Where we have provided benefits and a judgment or settlement is made with a no fault or liability insurer (or liable third party), you must reimburse us. However, our reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' compensation for treatment of a work-related illness or injury should also be applied to covered health care costs by this plan.

If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. (However, if your employer group plan coverage was secondary to Medicare when you developed ESRD because it was not based on current employment as described above, Medicare continues to be primary payer.)

Because of this, we may ask you for information about other insurance you may have. If you have other insurance, you can help us obtain payment from the other insurer by providing the information we request promptly.

Coordination of benefits protects you from higher Plan Premiums. The end result is more affordable health care.

Section 12 - Confidentiality and Release of Information

Information from your medical records and such information from Providers or Hospitals shall be kept confidential. Except as is necessary in connection with administering the Medicare contract and fulfilling State and federal requirements (including review programs to achieve quality medical care), such information will not be disclosed without your written consent.

Additionally, any personal information that you provide in the course of your enrollment is also protected and will remain confidential. We must ensure that unauthorized individuals cannot gain access to or alter your records.

[Add any State requirements as necessary.]

Section 13 - Adding Optional Supplemental Benefits

[*Note: This section is to be completed if the plan offers optional supplemental benefits. It is intended to separately describe the benefits, plan rules, and procedures to be followed by members who elect the optional supplemental coverage*.]

[Insert plan specific options and processes]

Electing Optional Supplemental Benefits

X Application Process, Effective Date, Premiums

X Discontinuing Your Optional Supplemental Benefits

X Refund Of Premium

Optional supplemental benefits are subject to the same appeals process as any other benefits.

[Note on failure to pay premiums: If the M+CO elects not to take action (i.e., downgrade or disenrollment) against members who fail to pay optional supplemental premiums, it is not necessary to state this in the EOC.]

[If the M+CO elects to either downgrade or disenroll a member who fails to pay optional supplemental premiums, insert the applicable statement]:

Failure to Pay Premiums for Optional Supplemental Benefits

[If you fail to pay Plan Premiums for Optional Supplemental Benefits within a 90-day grace period from when the premium is due, we will automatically downgrade you to our basic plan.]

[If you fail to pay Plan Premiums for Optional Supplemental Benefits within a 90-day grace period from when the premium is due, we will automatically disenroll you from the plan. Should you decide later to re-enroll in the plan, you must pay any premiums due from your previous enrollment in the plan.]

Section 14 - General Provisions

Governing Law

This Evidence of Coverage is subject to the laws of the State of [_____] and the United States of America, including: Title XVIII of the Social Security Act and regulations promulgated thereunder by HCFA. Any provisions required to be in this Evidence of Coverage by any of the above acts and regulations shall bind [name of M+C Organization] and you whether or not expressly provided in this document.

Member Non-Liability

In the event [name of M+C Organization] fails to reimburse a Contracting Medical Provider's charges for Covered Services or in the event that we fail to pay a Non-Contracting Medical Provider for Prior Authorized services, you shall not be liable for any sums owed by [name of M+C Organization].

However, you will be liable if you receive services from Non-Contracting Medical Providers without Prior Authorization, except for Emergency Services, Urgently Needed Services, or out-of-area dialysis services, neither [name of M+C Plan] nor Medicare will pay for those services. In addition, if you enter into a private contract with a Non-Contracting Medical Provider, neither [name of M+C Plan] nor Medicare will pay for those services.

[name of M+C Organization] Contracting Arrangements

In order to obtain quality service in an efficient manner, the [name of M+C Organization] pays its Providers using various payment methods, including capitation, per diem, incentive and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each Member assigned to the Provider. Per diem means paying a fixed dollar amount per day for all services rendered. Incentive means a payment which is based on appropriate medical management by the Provider. Discounted fee-for-service means paying the Provider's usual, customary and regular fee discounted by an agreed-to percentage.

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of Referrals and other services that you might need. To get this information, call our Customer Service Department at (800) xxx-xxxx [include TTY # for the "hearing impaired" - list hours of operation for both #s] and request information about our physician payment arrangements.

Physician-Patient Relationship

[name of M+C Plan] does not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on your behalf about:

X your health status, medical care, or treatment options;
X the risk, benefits, and consequences of treatment or non-treatment; or
X the opportunity for you to refuse treatment and to express preferences about future treatment decisions.

Facility Locations

Medical services are provided to [name of M+C Plan] Members through Contracting Medical Providers, Contracting Medical Groups and IPAs, Contracting Hospitals, and Contracting Pharmacies. For a complete list of Providers, please refer to the [name of M+C Plan] Provider Directory. If you have any questions regarding the Providers listed in the directory, please contact your [name of M+C Organization] Customer Service Representative.

For twenty-four (24) hour Emergency and/or Urgent visit telephone numbers, refer to either the [name of M+C Plan] Provider Directory or your membership card.

Notices

Any notice required to be given under this Evidence of Coverage shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other address as the parties may designate:

If to [name of M+C Organization]: [name of M+C Organization]
Attn: President
Address
City, State, ZIP

If to you, to your last address known to [name of M+C Organization]

Additional Information

As a [name of M+C Plan] Member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Statistical data on Grievances and Appeals
- The financial condition of [name of M+C Organization].
- Summary of Provider compensation arrangements.

Please contact Customer Service at 1-800 XXX-XXXX [include TTY # for the "hearing

impaired" - list hours of operation for both #s]

You may write to [name of M+C Organization] Corporate Offices at:
Address

Section 15 - M+C Plan's Service Area

You are eligible for enrollment and continued coverage as long as you reside in the area listed below:

[If approved for entire County, include County name. Zip Codes to be used for partially approved Counties only.]

Section 16 - M+C Plan's Schedule of Medical Benefits

Note: M+C Organizations must identify services that require prior authorization through use of asterisks and footnotes.

BENEFITS THROUGH A CONTRACTING MEDICAL PROVIDER	MEDICARE	M+C PLAN ($0 PER MONTH)	HIGH OPTION ($ PER MONTH)
Physician Services Office Visits including medical and surgical care in a physician's office or certified ambulatory surgical center Consultation, diagnosis and treatment by a Specialist Second opinion by another Contracting Medical Provider prior to surgery Outpatient Hospital services Outpatient surgical services Comprehensive outpatient rehabilitation facility services X-rays, including outpatient radiation therapy and portable X-rays used in the home Kidney dialysis Inpatient services including medical, surgical and psychiatric services	You pay the annual Part B deductible[1] plus 20% of Medicare approved charges[2].	List all applicable Copayments/Coinsurance and any additional benefits offered.	

Hospital Inpatient Care Semiprivate room (private if Medically Necessary) Meals including special diets Regular nursing services Costs of special care units, such as intensive care or coronary care units Drugs and medications Lab tests X-rays and other radiology services Necessary surgical and medical supplies Use of appliances, such as wheel chairs Operating and recovery room costs Rehabilitation services, such as physical therapy, occupational therapy and speech pathology services Kidney transplants and pancreas transplants, under certain conditions Heart, liver, lung and heart/lung transplants under certain conditions. Blood	Days one to sixty (1-60), in 1999 you pay a deductible of $776 in the Benefit Period[3]. For days sixty-one to ninety (61-90), you pay $194 per day. In addition, Medicare Part A includes an extra sixty (60) lifetime reserve days for Hospital stays greater than ninety (90) days. For days ninety-one to one-hundred-fifty (91-150), you pay $388 per day. You pay for the first three (3) pints of unreplaced blood.	List days covered and all applicable Copayments/Coinsurance List rules for coverage from reg 422.264	

Prescription Drugs Drugs and medicines you buy with a doctor's prescription.	Outpatient prescription drugs are not covered by Medicare except for immunosuppressive drugs for thirty-six (36) months following a Medicare covered organ transplant and under certain other conditions such as the following: Drugs and biologicals that cannot be self-administered (or drugs that require DME for administration - e.g. nebulizer, IV pump) and are furnished on an outpatient basis; Injectable drugs for the treatment of osteoporosis for the home-confined who cannot self-administer; Certain oral anti-cancer drugs; and Self administered erythropoietin. You pay the annual Part B deductible[1] plus 20% of remaining approved charges[2]. You may have to pay charges in excess of Medicare approved amounts if the Provider does not accept assignment.	Pharmacy network. Approved plan drug list. NOTE TO M+CO: You must describe here whether drugs must be from a Formulary or not. Also describe how often your Formulary is updated and whether members may be denied coverage for a maintenance medication mid-year, based on a Formulary change. Brand name; Copayments/Coinsurance; monthly, quarterly, annual limits [you MAY ONLY SHOW the lowest limit that applies, for instance, if you have a monthly limit YOU MAY NOT express this limit as a quarterly or annual limit]; mail order; number of days supply and etc. must all be described in detail. If monthly, quarterly, or annual limits are used, the M+C Organization must explain how the computation is done (i.e., AWP minus copay is deducted from the appropriate limit and etc.) For complete information regarding how your drug benefits are calculated, please contact [name of M+C plan] at [insert phone numbers].	

Emergency and Out-of-Area Urgently Needed Services[4] **Emergency Services-** Covered inpatient or outpatient services that are 1) furnished by a Provider qualified to furnish Emergency Services; and 2) Needed to evaluate or stabilize an Emergency Medical Condition. **Urgently Needed Services -** Covered Services provided when you are temporarily absent from the M+C Plan Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Contracting Medical Group is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through your Contracting Medical Group. **Renal dialysis services while temporarily outside of the service area.**	Emergency Services - You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do not pay this amount if you are admitted to the hospital for the same condition within 1-3 days of the emergency room visit. You pay 20% of doctor charges. Urgently needed services - You pay 20% of Medicare approved amounts or applicable copayment. Not covered outside the United States except under limited circumstances.	List Coverage and Copayments/Coinsurance. Member may not be charged more than the lesser of $50 for out-of-network emergency services or amount charged for in-network emergency services. List coverage and copayments/coinsurance if applicable.	

Skilled Nursing Facility Care Semiprivate room (private if medically necessary) Meals including special diets Regular nursing services Physical, occupational and speech therapy Drugs Blood Medical supplies Use of appliances such as wheelchairs	You pay nothing for up to twenty (20) days per Benefit Period following a Medically Necessary three (3) day Hospital stay. For days twenty-one (21) through one hundred (100) you pay $97 a day in accordance with Medicare guidelines.	List days covered, restrictions such as benefit period, all applicable Copayments/Coinsurance, and whether any prior Hospital stay is required.	
Home Health Care Part-time or intermittent Skilled Nursing Care. This can include up to eight (8) hours of reasonable and necessary care per day for up to twenty-one (21) consecutive days or longer in certain circumstances. Physical, occupational and speech therapy Part-time or intermittent services of home health aids Medical social services Medical supplies Durable Medical Equipment	Paid in full for all covered visits in accordance with Medicare guidelines. Durable Medical Equipment (DME) provided/used during home health care is covered. For DME you pay the annual Part B deductible1 plus 20% of remaining approved charges2.	List all applicable Copayments/Coinsurance.	
Hospice Care Pain relief, symptom management, and support services for the terminally ill. Home care is provided. Also covers necessary inpatient care and a variety of services usually not covered by Medicare.	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from any Medicare-certified hospice.	List all applicable copayments/coinsurance.	

Preventive Services **Routine Physical Examinations** **Mammography Screening** X-ray screening to detect breast cancer **Bone Mass Measurements** **Bone density tests for people with Medicare who are at risk** **Prostate Cancer Screening** (For men with Medicare age 50 and older) Digital Rectal Examination - Once every year. Prostate Specific Antigen (PSA) Test - Once every year.	Medicare does not usually cover routine physical exams. Mammogram covered annually for women age 40 and over. [Note to Health Plan: You MUST include the following statement in this column: "For mammography screening you may Self Refer to..."] Part B annual Deductible is waived. Medicare covers procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results subject to the annual Part B deductible,1 plus 20% of Medicare approved charges.2 You pay $0 for approved lab services and the annual Part B deductible1 plus 20% of remaining approved charges2 for other related services.	List Coverage and Copayments/Coinsurance. List Coverage and Copayments/Coinsurance. You may self refer to any Provider in your plan. List Coverage and Copayments/Coinsurance.	

Preventive Services (continued)			
Baseline Health Assessment	Medicare does not cover Baseline Health Assessments	List Coverage and Copayments/Coinsurance.	
Pap Smears (For women with Medicare)	You pay $0 for the Pap Smear once every 3 years, annually if high risk. Lab portion is covered in full for Pap smears when you use an assigned independent lab.	List Coverage and Copayments/coinsurance. No additional charge for laboratory services related to routine screening and examinations.	
Colorectal Screening Testing for early detection of colorectal cancer	Screening flexible sigmoidoscopy, every 4 years, 50 and over. Screening colonoscopy every 24 months for high risk. Screening barium enema covered as an alternative to either a screening sig. or a screening col., same frequency parameters apply. For individuals not at high risk of colorectal cancer - screening barium enema covered every 4 years. For individuals at high risk for colorectal cancer - payment may be made for screening barium enema every 2 years. You pay the annual Part B deductible[1], plus 20% of Medicare approved charges[2].	List Coverage and Copayments/Coinsurance.	

Preventive Services (continued) **Diabetes Monitoring** For all people with Medicare who have diabetes (insulin and non-insulin users.) Includes coverage for glucose monitors, test strips, lancets, and self-management training.	You pay the annual Part B deductible[1], plus 20% of Medicare approved charges[2].	List Coverage and Copayments/Coinsurance.	
Immunizations Pneumococcal pneumonia vaccine Flu shots Hepatitis B vaccine (for those at risk of contracting the disease)	You pay nothing for pneumococcal pneumonia vaccines and flu shots. For Hepatitis B vaccine you pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2]. Other immunizations not covered.	List Coverage and Copayments/Coinsurance. [Note to Health Plan: You MUST include the following statement in this column: "For flu shots you may Self Refer to..."]	
Blood and its administration	You pay for the first three (3) pints of blood used each year unless you have already paid for them as part of your hospital stay. For additional pints you pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2].	List Coverage and Copayments/Coinsurance.	

Other Services and Supplies Ambulance transportation, including air, water, or ground transport (Medical necessity limitations apply) Durable Medical Equipment Prosthetic devices including corrective lenses needed after a cataract operation, ostomy bags, and certain related supplies and breast prostheses (including a surgical brassiere) after a mastectomy) Medical supplies, such as dressings, splints, and casts Hemophilia clotting factors Antigens Therapeutic shoes for those with diabetic foot disease Oxygen and oxygen equipment.	You pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2]. You may have to pay for all charges above Medicare approved amounts for some of these services in the supplier does not accept assignment.	List Coverage and Copayments/Coinsurance.	

Outpatient Rehabilitation Services **Physical and Occupational Therapy and Speech and Language Therapy**	You pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2]. There is a maximum annual limit of $1,500 payable for <u>all</u> outpatient physical therapy services (including Speech-language pathology services), except for services furnished by a hospital outpatient department - which are unlimited. A separate annual $1,500 limit applies to <u>all</u> outpatient occupational therapy services, except for services furnished by a hospital outpatient department.	List Coverage and Copayments/Coinsurance.	
Hearing Services Routine hearing exam Hearing aids	You pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2] for diagnostic hearing exams. You pay 100% for routine hearing exams and hearing aids.	List Coverage and Copayments/Coinsurance. List Coverage and Copayments/Coinsurance.	

Podiatry Services Medical need Routine care	You pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2], covered for treatment of injuries and diseases of the feet. Routine foot care is generally not covered, unless the patient has a medical condition affecting the lower limbs.	List Coverage and Copayments/Coinsurance. List Coverage and Copayments/Coinsurance.	
Chiropractic Services Medical need Routine care	You pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2]. Limited to manual manipulation of the spine to correct subluxation. Not covered	List Coverage and Copayments/Coinsurance. List Coverage and Copayments/Coinsurance.	
Partial Hospitalization Services If a physician certifies that inpatient care would be necessary without it.	You pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2].	List Coverage and Copayments/Coinsurance.	

Laboratory Services	Medicare pays the full approved fee for laboratory tests.	List Coverage and Copayments/Coinsurance.	
Inpatient Mental Health Care	Coverage is the same as Hospital inpatient care with one-hundred-ninety (190) day lifetime limit in a free-standing psychiatric hospital.	List Coverage and Copayments/Coinsurance.	
Outpatient Mental Health Care	You pay 50% of approved charges after annual Part B deductible is met[1], except for the following services for which you pay the annual Part B deductible[1] and 20% of the Medicare approved charges[2]: Brief office visits for the sole purpose of monitoring or changing drugs; Partial hospitalization services that are not furnished by a physician; Diagnostic and testing services; Initial evaluations and visits; and Medical management services to treat patients with Alzheimers disease or dementia.	List Coverage and Copayments/Coinsurance.	

Vision Care Eye Care B Medical Need Frames, lenses and refractive eye exams	You pay the annual Part B deductible[1], plus 20% of Medicare approved charges[2], covered for medical eye problems. Routine eye exams and eyeglasses are not covered. Medicare will pay for one (1) pair of eyeglasses or contact lenses after each cataract surgery with insertion of an IOL (intraocular lens) subject to the annual Part B deductible,[1] plus 20% of Medicare approved charges.[2]	List all applicable Copayments/Coinsurance and any additional benefits you offer.	
Health Education [Programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets].	Not Covered.	List Coverage and Copayments/Coinsurance if applicable.	
Health Promotion [Programs designed to enrich the health and lifestyles of Members include weight management, smoking cessation, fitness and stress management.]	Not covered	List Coverage and Copayments/Coinsurance if applicable.	

Dental Services **Medical need**	You pay the annual Part B Deductible [1] and 20% of the Medicare approved charges,[2] limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a doctor.	List Coverage and Copayments/Coinsurance.	
Dental Services **Routine**	Not covered.	List Coverage and Copayments/Coinsurance.	

[1]$100 Part B deductible needs to be met only once per year and applies to all Medicare Part B benefits.

[2]If your doctor does not accept assignment, you pay any unapproved charges up to the Medicare limiting charge, which is 115% of the Medicare approved amount.

[3]A Benefit Period begins on the first day of admission to a Hospital and ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF. While Benefit Periods are renewable, lifetime reserve days are not.

[4]For a detailed explanation, please refer to your combined Evidence of Coverage and Disclosure Information. These services are also Covered Services at Non-Contracting Medical Providers.

Section 17 - Exclusions: Services Not Covered

Any services not provided or arranged by a Contracting Medical Provider or Prior Authorized (except for Emergency Services or Urgently Needed Services) are not covered by [name of M+C Plan] or by Medicare.

In addition to any Exclusions or limitations described in the Schedule of Medical Benefits, the following items and services are limited or Excluded under [name of M+C Plan]:

[NOTE: The following services are excluded from the Medicare benefit package that all M+C Organizations are required to cover. If any services below are covered as additional or supplemental benefits, they should be deleted from the list below.]

[NOTE to Health Plan: Since original Medicare does not cover prescription medications that can be self-administered, this exclusion is provided in the event that you offer an outpatient prescription drug benefit, but do not cover these particular types of medication].

- Prescription medication that can be self-administered for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.

- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.

- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by [name of M+C Organization] or Medicare.

- Acupuncture

- Religious Non-Medical Health Care Services.

- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction is covered when following a medically necessary mastectomy.

- Custodial Care, which includes care that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that is usually self-administered.

- Homemaker services, except for limited coverage in accordance with Medicare guidelines.

- Hospice services in a Medicare-participating Hospice are not paid for by [name of M+C Organization], but reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice. We will refer you to a Medicare-participating Hospice if you wish to elect such coverage. You may remain enrolled in [name of M+C Plan] even though you have elected Hospice coverage. You may continue to have your care unrelated to the terminal condition arranged through the [name of M+C Organization] and you may also use a Contracting Medical Provider as your Hospice attending physician.

- Meals delivered to your home.

- Naturopaths' services.

- Nursing care on a full-time basis in your home.

- Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge, except the M+C Plan will cover therapeutic shoes for those suffering from diabetic foot disease as outlined in the Schedule of Medical Benefits for "Outpatient Medical Services."

- Supportive devices for the feet, except the M+C Plan will cover orthopedic or therapeutic shoes as described above.

- Personal convenience items, such as a telephone or television in your room at a Hospital or Skilled Nursing Facility.

- Private duty nurses.

- Private room in a Hospital, unless Medically Necessary.

- Charges imposed by immediate relatives or members of your household.

- Services which are not reasonable and necessary under Medicare program standards.

- Reversal of sterilization procedures; sex change operations; conception by artificial means, such as in vitro fertilization, zygote intra fallopian transfers and gamete intra fallopian transfers (unless defined as covered); and non-prescription contraceptive supplies and devices. However, medically necessary services for infertility are covered.

- Emergency facility services for non-authorized, routine conditions that do not appear to a prudent layperson to be based on an emergency medical condition.

- Surgical treatment of morbid obesity unless determined Medically Necessary by a M+C Plan Medical Director or designee.

- Dental splints, dental prosthesis or any dental treatment for the teeth, gums or jaw or dental treatment related to temporomandibular joint syndrome (TMJ).

- Radial keratotomy and low vision aids and services.

- Experimental or investigational medical and surgical procedures, equipment and medications, that are otherwise not covered by Medicare.

- Dental, chiropractic and routine foot care are generally not covered under the M+C Plan or are limited according to Medicare guidelines. *However, these items are available under Optional Supplemental Benefits under certain circumstances. See Section 13*

[**NOTE to Health Plan:** If your health plan has received a specific waiver from HCFA for coverage of the limited abortion services covered by original fee-for-service Medicare, you are required to provide the following disclaimer. Please see OPL99.086 - "Medicare Coverage of Abortions." You are also required to list the specific services you will not provide and an alternative method (telephone number) for obtaining information on the covered services that you will not provide based on moral or religious grounds. Please contact your HCFA Central Office Plan Manager for additional information].

X Counseling or referral services which the Plan objects to based moral or religious grounds. The law requires us to inform both current and prospective enrollees of specific counseling and referral services that are normally part of the Medicare benefit package, but which we do not provide due to objections based on moral or religious grounds. In the case of [name of Health Plan] we will not provide counseling or referral services related to [enter the benefits for which you will not provide counseling or referral services, i.e., advance directives related to withholding nutrition/treatment, etc.].